

EXHIBIT E

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Pharmacy Claim Form (30-1) Completion

The *Pharmacy Claim Form (30-1)* is used by pharmacies to bill Medi-Cal for prescriptions and medical supplies.

Durable Medical Equipment (DME) and blood products must be billed using the *HCFA 1500* claim form. See the *HCFA 1500 Completion* section of this manual for information.

If billing for a compounded drug prescription, complete the *Compound Pharmacy Claim Form (30-4)*. Refer to the *Compound Pharmacy Claim Form (30-4) Completion* section of this manual for instructions on how to bill for compounded drug prescriptions.

Most claims for non-compounded drugs and medical supplies also may be submitted through the National Council for Prescription Drug Programs (NCPDP) Batch Standard, Version 1.1. For batch submission information, refer to the *CMC* section in the Part 1 manual.

Claims for compounded and non-compounded pharmaceutical products also may be submitted online through the Point of Service (POS) network. Claims submitted online will be immediately adjudicated, including program requirements, Drug Use Review (DUR), eligibility and Share of Cost (SOC) liability. Pharmacies may access the POS network using vendor-supplied hardware and software or a POS device available through EDS. For more information, call the Telephone Service Center (TSC) at 1-800-541-5555.

For information about billing via Computer Media Claims (CMC) or POS, refer to the *CMC* and *Point of Service (POS)* sections in the Part 1 provider manual.

Pharmacy providers with Internet access also may submit single compound and non-compound pharmacy claims using the Real-Time Internet Pharmacy (RTIP) claim submission system. To submit RTIP claim transactions on the Medi-Cal Web site, submitters must complete the *Medi-Cal Point of Service (POS) Network/Internet Agreement* and send to:

Attn: POS/Internet Help Desk
EDS
3215 Prospect Park Drive
Rancho Cordova, CA 95670-6017

RTIP submitters also must complete the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* and send to:

Attn: CMC Unit
EDS
P.O. Box 15508
Sacramento, CA 95852-1508

Crossover pharmacy claims that do not cross over automatically via NCPDP must be billed on the *Pharmacy Claim Form (30-1)*. These claims cannot be billed via CMC, POS, or RTIP. For more information and billing examples, refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services Billing Examples* section of this manual.

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DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER - FOR F.I. USE ONLY

FASTEN HERE

PHARMACY CLAIM FORM

Provider Name, Address

3A

2 ID QUALIFIER 3 PROVIDER ID

4 ZIP CODE

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES

Provider Phone Number:

ELITE PICA

TYPEWRITER ALIGNMENT

ELITE PICA

PATIENT INFORMATION

5 PATIENT NAME (LAST, FIRST, M.I.)

6 MEDICAL IDENTIFICATION NO.

7 SEX

8 DATE OF BIRTH

9 PATIENT LOCATION

10 MEDICARE STATUS

11 PRESCRIPTION NO.

12 DATE OF SERVICE

13 METRIC QUANTITY

14 CODE 1 MET?

15 DAYS SUPPLY

16 BASIS OF COST DETERMINATION

17 PROD ID QUAL

18 PRODUCT ID

19 ID QUAL

20 PRESCRIBER ID

21 PRIMARY ICD-CM

22 SECONDARY ICD CM

23 CHARGE

24 OTHER COVERAGE PAID

25 OTH COV CODE

26 PATIENT'S SHARE

27 TAR CONTROL NO

28 COMP CODE

29 DELETE

30 PRESCRIPTION NO.

31 DATE OF SERVICE

32 METRIC QUANTITY

33 CODE 1 MET?

34 DAYS SUPPLY

36 BASIS OF COST DETERMINATION

35 PROD ID QUAL

37 PRODUCT ID

38 ID QUAL

39 PRESCRIBER ID

40 PRIMARY ICD-CM

41 SECONDARY ICD CM

42 CHARGE

43 OTHER COVERAGE PAID

44 OTH COV CODE

45 PATIENT'S SHARE

46 TAR CONTROL NO

47 COMP CODE

48 DELETE

49 PRESCRIPTION NO.

50 DATE OF SERVICE

51 METRIC QUANTITY

52 CODE 1 MET?

53 DAYS SUPPLY

54 BASIS OF COST DETERMINATION

55 PROD ID QUAL

56 PRODUCT ID

57 ID QUAL

58 PRESCRIBER ID

59 PRIMARY ICD-CM

60 SECONDARY ICD CM

61 CHARGE

62 OTHER COVERAGE PAID

63 OTH COV CODE

64 PATIENT'S SHARE

65 TAR CONTROL NO

66 COMP CODE

67 DELETE

68 PRESCRIPTION NO.

69 DATE OF SERVICE

70 METRIC QUANTITY

71 CODE 1 MET?

72 DAYS SUPPLY

73 BASIS OF COST DETERMINATION

74 PROD ID QUAL

75 PRODUCT ID

76 ID QUAL

77 PRESCRIBER ID

78 PRIMARY ICD-CM

79 SECONDARY ICD CM

80 CHARGE

81 OTHER COVERAGE PAID

82 OTH COV CODE

83 PATIENT'S SHARE

84 TAR CONTROL NO

85 COMP CODE

86 DELETE

SPECIFIC DETAILS/REMARKS:

95

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

94

94 Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

87 MEDICAL RECORD NO.

88 BILL LINE

89 ATTACHMENTS

90 DATE BILLED

91 DISCHARGE DATE

92 F.I. USE ONLY

93

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. FORWARD TO APPROPRIATE F.I.

30-1CZ RV7

Figure 1. Medi-Cal Required Fields (Sample Pharmacy Claim Form [30-1]).

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *Pharmacy Claim Form* (30-1) on the previous page. All items must be completed unless otherwise noted in these instructions.

For general paper claim billing instructions, refer to the *Forms: Legibility and Completion Standards* Section of this manual.

<u>Item</u>	<u>Description</u>
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- | | |
|----|---|
| 1. | CLAIM CONTROL NUMBER. For EDS use only. Do not mark in this area. A unique 13-digit number, assigned by EDS to track each claim, will be entered here when the claim is received by EDS. |
| 2. | ID QUALIFIER. Identifies the NCPDP 5.1 standard provider ID type. Place a 05 for Medi-Cal Pharmacy Provider ID. |
| 3. | PROVIDER NUMBER. Enter your Medi-Cal provider number if this information is not pre-imprinted. Be sure to include all <u>nine</u> characters of the number. |

Do not submit claims using a Medicare provider number or State license number.

Provider ID
Number Change

When a provider is assigned a new provider identification number by the DHS Provider Enrollment Section, a beginning date is listed. When billing for dates of service on or after this beginning date, the new number should be used. When billing for dates of service prior to this beginning date, the old provider identification number is to be used.

Pre-imprinted Claim Forms

Providers using pre-imprinted claim forms should keep some blank claim forms on hand that are pre-imprinted with the old number until the Medi-Cal accounts are reconciled for dates of service prior to the beginning date of the new number.

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Billing Services

- | Item | Description |
|------|---|
| 3. | <p>PROVIDER NUMBER (continued).</p> <p>Providers using a billing service should notify the service to amend its records so that the correct provider number for the date of service will appear on the claim.</p> <p>CHECK DIGIT. A check digit is used by EDS to verify accurate input of the Medi-Cal provider ID number. Although the claim form does not indicate a Check Digit box, the check digit can be placed three spaces to the right of the provider number. The check digit is <u>not</u> a required item. However, it is recommended to ensure payment for the claim is made to the correct provider. If you do not know your check digit, you may contact the Provider Support Center (PSC) at 1-800-541-5555.</p> |
| 3a. | <p>PROVIDER NAME, ADDRESS, PHONE NUMBER. Enter your name, address and telephone number if this information is not pre-imprinted on the claim form. Confirm that this information is correct before submitting claim forms.</p> |
| 4. | <p>ZIP CODE. Enter the pharmacy's five-digit ZIP code if this information is not already pre-imprinted on the claim form.</p> |

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Newborn Infant

Item Description

5. **PATIENT NAME.** Enter the patient's last name, first name, and middle initial, if known. Avoid nicknames or aliases.

When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name, sex and year of birth in the appropriate spaces. Enter the complete date of birth (MMDDYYYY) and write "Newborn infant using mother's card" in the *Specific Details/Remarks* area.

If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones, Baby Girl). If newborn infants from a multiple birth are being billed in addition to the mother, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A).

Services to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.

6. **MEDI-CAL IDENTIFICATION NUMBER.** Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC).
7. **SEX.** Use the capital letter "M" for male, or "F" for female. Obtain the sex indicator from the BIC. (For newborns, see *Item 4.*)

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<u>Item</u>	<u>Description</u>
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|----|--|
| 8. | DATE OF BIRTH. Obtain this number from the recipient's BIC. Although the form utilizes MMDDYYYY format, enter the date in MMDDCCYY format, where "MM" is the two-digit month, "DD" is the two-digit day, "CC" is the two-digit century and "YY" is the two-digit year. For example, a birth date of March 8, 1945 should be entered as "03081945." Birth dates may not be in the future. You must enter this information in order for your claim to process successfully. |
| 9. | PATIENT LOCATION. If the recipient is residing in a Nursing Facility (NF) Level A or B or Nursing Facility Level B (Subacute Care), enter the appropriate code in this field: <ul style="list-style-type: none"> C – Nursing Facility (NF) Level A 4 – Nursing Facility (NF) Level B F – Nursing Facility (NF) Level B (Adult Subacute) F – Subacute Care Facility G – Intermediate Care Facility–Developmentally Disabled (NF-A/DD) H – Intermediate Care Facility–Developmentally Disabled, Habilitative (NF-A/DD-H) I – Intermediate Care Facility–Developmentally Disabled, Nursing (NF-A/DD-N) M – Nursing Facility Level B (Pediatric Subacute) |

If the recipient is not residing in any of these facilities, leave Item 9 blank.

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7Item Description

10. **MEDICARE STATUS.** Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are:

<u>Code</u>	<u>Explanation</u>
0	Under 65, does not have Medicare coverage
* 1	Benefits exhausted
* 2	Utilization committee denial or physician non-certification
* 3	No prior hospital stay
* 4	Facility denial
* 5	Non-eligible provider
* 6	Non-eligible recipient
* 7	Medicare benefits denied or cut short by Medicare intermediary
8	Non-covered services
* 9	PSRO denial
* L	Medi/Medi Charpentier: Benefit limitations
* R	Medi/Medi Charpentier: Rates
* T	Medi/Medi Charpentier: Both rates and benefit limitations

* Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* section in this manual for additional information.

11. **PRESCRIPTION NUMBER.** Enter your prescription number in this space for reference on the *Remittance Advice Details* (check warrant and voucher). A maximum of eight digits may be used.

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<u>Item</u>	<u>Description</u>
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- | | |
|-----|--|
| 12. | DATE OF SERVICE. Although Medi-Cal utilizes a six-digit date of service field on all other claim types (including the <i>HCFA 1500</i>), enter the date that the prescription was filled in eight-digit MMDDYYYY (Month, Day, Year) format (for example, August 6, 2001 = 08062001). |
|-----|--|

- | | |
|-----|-------------------------|
| 13. | METRIC QUANTITY. |
|-----|-------------------------|

For dates of service prior to October 1, 2002:

The quantity dispensed must be submitted as a whole number. For example, a quantity of 3.5 should be rounded up to 4 and submitted as "4.000". The field must include trailing zeroes.

A quantity of 100 should be billed as "100.000".

For dates of service on or after October 1, 2002:

The quantity dispensed must be submitted in metric decimal form. For example, a quantity of 3.5 must be submitted as "3.500". The field must include trailing zeros.

Do not include measurement units such as Gm or cc.

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<u>Item</u>	<u>Description</u>
13.	METRIC QUANTITY (continued).
Use Correct Measurement Unit	The correct measurement unit is listed beside each item in the Contract Drugs List sections. This is the measurement unit you should use for billing. For items requiring a <i>Treatment Authorization Request</i> (TAR), the approved TAR will specify the exact number of units to be used in the quantity field of the claim form.
Package Size Specific Codes	<p>The listings in the <i>Medical Supplies List</i> and the Contract Drugs List sections of this manual are sometimes package-size specific. That is, a different code is assigned to different package sizes of the same drug or medical supply.</p> <p>In such cases, use the code that corresponds to a trade package actually made by the manufacturer whose product is dispensed. If the manufacturer does not make a trade package containing the quantity dispensed, use the code that corresponds to the package size that was used in filling the prescription. For instance, if 60 grams of an ointment are dispensed out of a 454 Gm jar, the code for the 454 Gm jar should be used.</p>
Prepacks	The units (Gm's, cc's or each) that are to be used when billing the program are specified in the item's listing. The units specified must be used in all cases. The quantity entered for prepacks should always be in the number of units specified in the Contract Drugs List sections.
14.	CODE 1 (RESTRICTIONS) MET? A "Y" means that the Code 1 restriction listed under the drug in the Contract Drugs List sections has been met.
15.	DAYS SUPPLY. Enter the estimated number of days that the drug dispensed will last.

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- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 16. | BASIS OF COST DETERMINATION. This field indicates the method by which the ingredient cost was calculated. Enter "09" (Other) if the cost basis is Disproportionate share/Public Health Service or the drug is purchased under the 340B Drug Discount Program. Otherwise enter "00" (Not specified). |
| 17. | PRODUCT ID QUALIFIER. This field identifies the type of product ID submitted. Place a "03" for National Drug Code (NDC) in this field or "99" for medical supplies. |
| 18. | PRODUCT ID. When billing for drugs, enter the NDC, Universal Product Code (UPC) or Health Related Items (HRI) code of the drug billed. Enter the Medi-Cal manufacturer billing and type codes when billing for medical supplies. |

Zero Fill NDC Numbers

All NDC numbers must be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into three segments. For a complete 11-digit number, the first segment must have five digits, the second segment four digits and the third segment two digits. Add leading zeros wherever they are needed to complete a segment with the correct number of digits. For example:

<u>Package Number</u>	<u>Zero Fill</u>	<u>11-digit NDC</u>
1234-1234-12	(01234-1234-12)	01234123412
12345-123-12	(12345-0123-12)	12345012312
2-22-2	(00002-0022-02)	00002002202

<u>Item</u>	<u>Description</u>
18.	PRODUCT ID (continued).
Drug Manufacturer and Product Codes	If the item being billed is a drug, check the list found in the <i>Drugs: Contract Drugs List Part 5 – Authorized Drug Manufacturer Labeler Codes</i> section of this manual. The products of manufacturers not listed in this section are not covered by Medi-Cal without prior authorization.
Medical Supply Manufacturer and Product Codes	<p>If the item being billed is a medical supply, use the manufacturer code found in the <i>Medical Supplies: Manufacturer Billing Codes</i> section of this manual and the product code found in the Medical Supplies List sections of this manual.</p> <p>When billing on a 30-1 claim form, enter the two-digit manufacturer code <u>before</u> the five-digit medical supply code. For example, if the manufacturer billing code for medical supply code 9917B is "OT," then enter the code as "OT9917B". Be sure to enter the code right-justified.</p> <p>Providers billing on the <i>HCFA 1500</i> claim form should refer to the <i>HCFA 1500 Completion</i> section of this manual for instructions on how to bill for medical supply codes.</p> <p>Note: Effective November 1, 2003, billing for a medical supply with code 9999A requires providers to submit, as an attachment, a copy of the original <i>Treatment Authorization Request (TAR)</i> along with appropriate pricing documentation (for example, invoice or manufacturer catalog page) with the claim. Indicate the name of the supply, principal labeler and quantity in the <i>Specific Details/Remarks</i> area. Medical supplies cannot be billed through the POS network.</p>
Billing for TAR-Authorized Services	When billing for an item authorized by a TAR, use the manufacturer/type code specified on the TAR.

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- | Item | Description |
|------|---|
| 19. | ID QUALIFIER. Identifies the NCPDP 5.1 standard provider ID type. Enter "08" to indicate the State license number. "08" is the NCPDP code used to identify the contents of field 20 (the State license number). |
| 20. | PRESCRIBER ID. Enter the provider's State license number in this box. Do not use the Drug Enforcement Administration (DEA) Narcotic Registry Number. This information must be entered for your claim to successfully process. |
| 21. | PRIMARY ICD-CM. Optional. If available, enter all letters and/or numbers of the <i>International Classification of Diseases – 9th Revision – Clinical Modification</i> (ICD-9-CM) code for the primary diagnosis, including the fourth and fifth digits, if present. Do not enter the decimal point. |
| 22. | SECONDARY ICD-CM. Optional. The primary diagnosis code should be placed in the first occurrence and the secondary should be placed in the second occurrence. |
| 23. | CHARGE. Enter the dollar and cents amount for this item. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). If the item is taxable, include the applicable state and county sales tax for each claim line total. For DMERC NCPDP hardcopy pharmacy crossovers, enter the Medicare Allowed Amount. |
| 24. | OTHER COVERAGE PAID. Enter the full dollar amount of payment received from Other Health Coverage carriers. Do not enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. For DMERC NCPDP hardcopy pharmacy crossovers, add the Other Health Coverage Amount(s) and Medicare Paid Amount, then enter the combined total. |

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<u>Item</u>	<u>Description</u>
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25. **OTHER COVERAGE CODE.** A valid Other Coverage Code is required. Enter one of the following values:

<u>Code</u>	<u>Explanation</u>
0	Not Specified or No Other Coverage Exists
2	Other Coverage Exists, Payment Not Collected
7	Other Coverage Exists, Claim was not covered or other coverage was not in effect at time of service
9	Other Coverage Exists, Payment Collected

26. **PATIENT'S SHARE (OF COST).** Enter the full dollar amount of the patient's Share of Cost for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. For more information, see the *Share of Cost (SOC): 30-1 for Pharmacy* section in this manual.

27. **TAR CONTROL NUMBER.** If prior authorization is required, enter the 11-digit TAR Control Number (TCN) from your copy of the approved TAR on each applicable claim line. It is not necessary to attach a copy of the TAR to the claim. Recipient, quantity, drug and date of service on the claim must agree with the information on the TAR.

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Item Description

28. **COMPOUND CODE.** Enter the appropriate code in this box.

<u>Code</u>	<u>Description</u>
0	Not specified
1	Not a compound
2	Compound

Note: Compound pharmacy claims should be billed on the *Compound Pharmacy Claim Form (30-4)* or electronically through the POS network or Real-Time Internet Pharmacy (RTIP) claim submission system.

29. **DELETE.** If an error has been made, enter an "X" in this space to delete the entire line. Enter the correct billing information on another line. When a *Delete* box is marked "X", the information on the line will be "ignored" by the system and will not be entered as a claim line.

30 – 86. **ADDITIONAL CLAIM LINES.** Lines 2, 3 and 4 are used for additional items for the same patient during the same month of service.

87. **MEDICAL RECORD NUMBER.** This is an optional field that will help you to easily identify a recipient on RTDs. Enter the patient's medical record number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever you enter here will appear on the RTD. Refer to the *Resubmission Turnaround Document (RTD) Completion* section in this manual for more information.

If the pharmacy does not assign unique record-keeping numbers to each recipient, it is recommended that the recipient's name be entered in this field.

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- | Item | Description |
|---------|--|
| 88. | BILLING LIMIT EXCEPTIONS. If there is an exception to the six-month billing limitation, enter the appropriate reason code number and include the required documentation. (See the <i>Pharmacy Claim Form [30-1] Submission and Timeliness Instructions</i> section of this manual.) |
| 89. | ATTACHMENTS. Enter an "X" if attachments are included with the claim (for example, catalog pages, invoices, etc.). <u>Leave blank if not applicable.</u>

Reminder: If this box is not marked, attachments may not be seen by the claim examiner, which may cause the claim to be denied. |
| 90. | DATE BILLED. Enter the date this statement is being submitted to EDS for processing. Use numbers as described in <i>Item 12</i> (Date of Service). |
| 91. | DISCHARGE DATE. Leave blank. This will be used for the date the patient was discharged from the hospital. |
| 92, 93. | F.I. USE ONLY. Leave blank. |
| 94. | SIGNATURE OF PROVIDER AND DATE. The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only.

An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file at EDS. |

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Item	Description
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- | | |
|-----|---|
| 95. | <p>SPECIFIC DETAILS/REMARKS. Use this blank space to clarify or detail any line item. <u>Indicate the line item number being referenced.</u> If additional space is needed, insert a capital "X" or "Y" in Box 89 (<i>Attachments</i>) and clip or staple your attachment to the top right-hand corner of the claim.</p> |
|-----|---|

The *Specific Details/Remarks* area is also used to provide information on Share of Cost, Crossovers or Charpentier Rebilling. See the *Pharmacy Claim Form (30-1): Special Billing Instructions* section, the *Share of Cost: (30-1) for Pharmacy* section or the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* section of this manual for more information.

Emergency Certification Statement

Claims that require documentation, such as an Emergency Certification Statement, cannot be billed through the POS network or CMC format. The Emergency Certification Statement must be attached to the claim and include:

- The nature of the emergency, including relevant clinical information about the patient's condition
- Why the emergency services rendered were considered to be immediately necessary
- The signature of the physician, podiatrist, dentist or pharmacist who had direct knowledge of the emergency

The statement must be comprehensive enough to support a finding that an emergency existed. A mere statement that an emergency existed is not sufficient.

An Emergency Certification Statement may not be used in place of a Treatment Authorization Request (TAR) for diabetic supplies that require prior authorization when the maximum quantity has been reached. For further information, see the *Medical Supplies* section in this manual.

Note: Emergency claims cannot be billed using the CMC format or through the POS network.